OPTIMA HEALTH COMMUNITY CARE

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-319-5003. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: Triumeq® (abacavir/dolutegravir/lamivudine)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Quantity per Day: ____

Dosing Schedule: ____________________________ **Length of Therapy:** __________________

Diagnosis: _________________________________ ***ICD Code, if applicable:*** ______________

CLINICAL CRITERIA: To receive a ONE (1) year approval for this drug, ALL appropriate boxes below must be checked to qualify or authorization process will be delayed.

Does member meet the following criteria?

- Is member 18 years of age or older? ❑ Yes ❑ No
- Screening results for HLA-B 5701 allele:
  - HLA-B 5701 allele absent? ❑ Yes ❑ No

  NOTE: Triumeq® is contraindicated in patients who are positive for this allele

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request.

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*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ____

Member Optima #: ______________________________ Date of Birth: __________________

Prescriber Name: ____

Prescriber Signature: _________________________________ Date: __________________

Office Contact Name: ____

Phone Number: _______________________________ Fax Number: ____________________

DEA OR NPI #: ____

REVISED/UPDATED: 12/23/2017